

EXHIBIT *ZZ*



U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION INTAKE QUESTIONNAIRE

Please immediately complete this entire form and return it to the U.S. Equal Employment Opportunity Commission ("EEOC"). REMEMBER, a charge of employment discrimination must be filed within the time limits imposed by law, within 180 days or in some places within 300 days of the alleged discrimination. When we receive this form, we will review it to determine EEOC coverage. Answer all questions completely, and attach additional pages if needed to complete your responses. If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "N/A." (PLEASE PRINT)

1. Personal Information

Last Name: IRANI First Name: AFRAAZ
 Street or Mailing Address: 673 LOS OLIVOS DR. Apt or Unit #: _____
 City: SANTA CLARA County: SANTA CLARA State: CA Zip: 95050
 Phone Numbers: Home: () _____ Work: () _____
 Cell: (650) 353-8523 Email Address: AFRAAZ.IRANI@HOTMAIL.COM
 Date of Birth: 05/14/1983 Sex: ☒ Male ☐ Female Do You Have a Disability? ☐ Yes ☐ No

Please answer each of the next three questions. i. Are you Hispanic or Latino? ☐ Yes ☒ No
 ii. What is your Race? Please choose all that apply. ☐ American Indian or Alaskan Native ☒ Asian ☐ White
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

iii. What is your National Origin (country of origin or ancestry)? INDIA / IRAN / Zoroastrian

Please Provide The Name Of A Person We Can Contact If We Are Unable To Reach You:

Name: _____

Address: _____

Home Phone: _____

2. I believe that I was discriminated against by the following organization(s): (Check those that apply)

☒ Employer ☐ Union ☐ Employment Agency ☐ Other (Please Specify) _____

Organization Contact Information (If the organization is an employer, provide the address where you actually worked. If you work from home, check here ☐ and provide the address of the office to which you reported.) If more than one employer is involved, attach additional sheets.

Organization Name: PALMETTO HEALTH / UNIVERSITY OF SOUTH CAROLINA DEPARTMENT OF ORTHOPEDIC

Address: THE MEDICAL PARK, SUITE LOWER LEVEL County: RICHLAND

City: COLUMBIA State: SC Zip: 29203 Phone: (803) 434-6812

Type of Business: HOSPITAL Job Location if different from Org. Address: _____

Human Resources Director or Owner Name: AMY BARRY Phone: (803) 296-5220

Number of Employees in the Organization at All Locations: Please Check (✓) One

☐ Fewer Than 15 ☐ 15 - 100 ☐ 101 - 200 ☐ 201 - 500 ☒ More than 500

3. Your Employment Data (Complete as many items as you are able.) Are you a federal employee? ☐ Yes ☒ No

Date Hired: 6/10 Job Title At Hire: ORTHOPEDIC SURGERY RESIDENT

Pay Rate When Hired: ~\$50,000/yr Last or Current Pay Rate: ~\$50,000/yr

Job Title at Time of Alleged Discrimination: Orthopedic Surgery Resident Date Quit/Discharged: 6/1/12

Name and Title of Immediate Supervisor: DR. DAVID E. KOEN JR.

If Job Applicant, Date You Applied for Job _____ Job Title Applied For _____

4. What is the reason (basis) for your claim of employment discrimination?

FOR EXAMPLE, if you feel that you were treated worse than someone else because of race, you should check the box next to Race. If you feel you were treated worse for several reasons, such as your sex, religion and national origin, you should check all that apply. If you complained about discrimination, participated in someone else's complaint, or filed a charge of discrimination, and a negative action was threatened or taken, you should check the box next to Retaliation.

☒ Race ☐ Sex ☐ Age ☐ Disability ☒ National Origin ☒ Religion ☒ Retaliation ☐ Pregnancy ☐ Color (typically a difference in skin shade within the same race) ☐ Genetic Information; circle which type(s) of genetic information is involved:
i. genetic testing ii. family medical history iii. genetic services (genetic services means counseling, education or testing)

If you checked color, religion or national origin, please specify: Zoroastrian faith from high middle east area originally

If you checked genetic information, how did the employer obtain the genetic information? _____

Other reason (basis) for discrimination (Explain): _____

5. What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and the name(s) and title(s) of the person(s) who you believe discriminated against you. Please attach additional pages if needed.
(Example: 10/02/06 - Discharged by Mr. John Soto, Production Supervisor)

A. Date: 6/1/12 Action: CONFIRMATION OF DISMISSAL

Name and Title of Person(s) Responsible: DR. DAVID E. KOEN JR.

B. Date: _____ Action: _____

Name and Title of Person(s) Responsible _____

6. Why do you believe these actions were discriminatory? Please attach additional pages if needed.

(please see attachment)

7. What reason(s) were given to you for the acts you consider discriminatory? By whom? His or Her Job Title?

(please see attachment)

8. Describe who was in the same or similar situation as you and how they were treated. For example, who else applied for the same job you did, who else had the same attendance record, or who else had the same performance? Provide the race, sex, age, national origin, religion, or disability of these individuals, if known, and if it relates to your claim of discrimination. For example, if your complaint alleges race discrimination, provide the race of each person; if it alleges sex discrimination, provide the sex of each person; and so on. Use additional sheets if needed.

Of the persons in the same or similar situation as you, who was treated better than you?

Full Name	Race, Sex, Age, National Origin, Religion or Disability	Job Title	Description of Treatment
A. DR. HARRISON GORDON	WHITE	ORTHOPAEDIC RESIDENT	RESIDENT
IN SIMILAR SITUATION AND TRAINING NOT CITED			

B. (please see attachment for addendum)

Of the persons in the same or similar situation as you, who was treated *worse* than you?

<u>Full Name</u>	<u>Race, Sex, Age, National Origin, Religion or Disability</u>	<u>Job Title</u>	<u>Description of Treatment</u>
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A. _____

B. _____

Of the persons in the same or similar situation as you, who was treated the *same* as you?

<u>Full Name</u>	<u>Race, Sex, Age, National Origin, Religion or Disability</u>	<u>Job Title</u>	<u>Description of Treatment</u>
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A. _____

B. _____

Answer questions 9-12 only if you are claiming discrimination based on disability. If not, skip to question 13. Please tell us if you have more than one disability. Please add additional pages if needed.

9. Please check all that apply:

- ☐ Yes, I have a disability
☐ I do not have a disability now but I did have one
☐ No disability but the organization treats me as if I am disabled

10. What is the disability that you believe is the reason for the adverse action taken against you? Does this disability prevent or limit you from doing anything? (e.g., lifting, sleeping, breathing, walking, caring for yourself, working, etc.).

11. Do you use medications, medical equipment or anything else to lessen or eliminate the symptoms of your disability?

☐ Yes ☐ No

If "Yes," what medication, medical equipment or other assistance do you use?

12. Did you ask your employer for any changes or assistance to do your job because of your disability?

☐ Yes ☐ No

If "Yes," when did you ask? _____ How did you ask (verbally or in writing)? _____

Who did you ask? (Provide full name and job title of person)

Describe the changes or assistance that you asked for: _____

How did your employer respond to your request? _____

13. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and tell us what they will say. (Please attach additional pages if needed to complete your response)

Full Name	Job Title	Address & Phone Number	What do you believe this person will tell us?
A. DR. HARRISON GOODEN	ORTHOPEDIC RESIDENT	TWO RICHMOND PARK, SUITE LOWER LEVEL, 904-408-6890	
		RICHMOND COUNTY, COLUMBIA, SC 29203	Inequitable treatment, racial slurs
B. FRANNIE	NURSE	4344 BROAD RIVER ROAD, COLUMBIA, SC, 29210 803-896-1521	racial slurs

14. Have you filed a charge previously on this matter with the EEOC or another agency? ☐ Yes ☒ No

15. If you filed a complaint with another agency, provide the name of agency and the date of filing: _____

16. Have you sought help about this situation from a union, an attorney, or any other source? ☒ Yes ☐ No
Provide name of organization, name of person you spoke with and date of contact. Results, if any?

DAVID ROTHSTEIN, ROTHSTEIN LAW FIRM, PA 12/12-current
ADVISED TO CONTACT EEOC.

Please check one of the boxes below to tell us what you would like us to do with the information you are providing on this questionnaire. If you would like to file a charge of job discrimination, you must do so either within 180 days from the day you knew about the discrimination, or within 300 days from the day you knew about the discrimination if the employer is located in a place where a state or local government agency enforces laws similar to the EEOC's laws. If you do not file a charge of discrimination within the time limits, you will lose your rights. If you would like more information before filing a charge or you have concerns about EEOC's notifying the employer, union, or employment agency about your charge, you may wish to check Box 1. If you want to file a charge, you should check Box 2.

BOX 1 ☐ I want to talk to an EEOC employee before deciding whether to file a charge. I understand that by checking this box, I have not filed a charge with the EEOC. I also understand that I could lose my rights if I do not file a charge in time.

BOX 2 ☒ I want to file a charge of discrimination, and I authorize the EEOC to look into the discrimination I described above. I understand that the EEOC must give the employer, union, or employment agency that I accuse of discrimination information about the charge, including my name. I also understand that the EEOC can only accept charges of job discrimination based on race, color, religion, sex, national origin, disability, age, genetic information, or retaliation for opposing discrimination.


Signature

3/10/13
Today's Date

PRIVACY ACT STATEMENT: This form is covered by the Privacy Act of 1974: Public Law 93-579. Authority for requesting personal data and the uses thereof are:

- 1) **FORM NUMBER/TITLE/DATE.** EEOC Intake Questionnaire (9/20/08).
- 2) **AUTHORITY.** 42 U.S.C. § 2000e-5(b), 29 U.S.C. § 211, 29 U.S.C. § 626, 42 U.S.C. 12117(a)
- 3) **PRINCIPAL PURPOSE.** The purpose of this questionnaire is to solicit information about claims of employment discrimination, determine whether the EEOC has jurisdiction over those claims, and provide charge filing counseling, as appropriate. Consistent with 29 CFR 1601.12(b) and 29 CFR 1626.8(c), this questionnaire may serve as a charge if it meets the elements of a charge.
- 4) **ROUTINE USES.** EEOC may disclose information from this form to other state, local and federal agencies as appropriate or necessary to carry out the Commission's functions, or if EEOC becomes aware of a civil or criminal law violation. EEOC may also disclose information to respondents in litigation, to congressional offices in response to inquiries from parties to the charge, to disciplinary committees investigating complaints against attorneys representing the parties to the charge, or to federal agencies inquiring about hiring or security clearance matters.
- 5) **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION.** Providing this information is voluntary but the failure to do so may hamper the Commission's investigation of a charge. It is not mandatory that this form be used to provide the requested information.